CONSULTANT'S CORNER

MEDICAL RECORDS

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In this article, the Former Associate Chief of Staff for Education at the Long Beach VA Medical Center discusses medical records from a legal perspective. A President Emeritus of the American College of Legal Medicine, the author publishes, lectures, and consults extensively on malpractice prevention, risk management and bioethical topics.

INTRODUCTION

In today's complex health care environment, medical records take on increasing importance in documenting patient care. A good medical record constitutes a reliable means of communication among various professionals delivering health care to a patient. With the large number of providers who practice in any medical center or outpatient clinic, it is impossible for one practitioner to inform all the others individually when reporting findings, conclusions, recommendations, or follow-up observations. In such a setting, the sole means of effective communication is the medical record. Accordingly, a carefully prepared and comprehensive medical record is the patient's best assurance of quality care and continuity of that care.

Secondly, with the advent of health care reform, increasing importance has been granted clinical guidelines in arriving at diagnoses and determining propriety of treatment. Careful and thoughtful medical record documentation provides strong evidence of practice within guidelines and, when deviation from guidelines becomes necessary, support for a deviation. In many settings, either compliance with guidelines or careful documentation supporting a deviation may be necessary to assure reimbursement, the appropriate privileging of providers, or certification of the facility.

Thirdly, administrative programs, such as Total Quality Management (TQM) and Continuous Quality Improvement (CQI), have heightened the emphasis placed on the review of medical records to monitor and assess clinical outcomes.

Given our society's present medicolegal climate, however, the greatest concern regarding the medical record for many physicians is its use as evidence when a claim of medical professional negligence or malpractice arises. In any malpractice trial, the most important evidence presented to the court is the medical record. A good record bespeaks good medical care. If the clinical outcome is especially adverse and the pertinent medical records are particularly deficient, liability may be inferred. A significant percentage of medical malpractice suits are rendered indefensible due to material deficiencies in the related medical records. This is true even when appropriate care may have been actually rendered. Rarely, if ever, can a malpractice claim be defended successfully without a sound medical record.

Since most malpractice suits are not tried for several years, and the memories of individuals can be unreliable in such circumstances, the medical record assumes added importance.

In a malpractice suit, the physician's treatment of the patient is measured against what the law calls the "standard of care." The court assesses the physician's professional conduct to determine whether it

adhered to or deviated from the standards of practice required by both medicine and the law. The medical record, therefore, provides a legal index or guide to the professional conduct under scrutiny. It supports conclusions regarding the physician's competence and, as a matter of law, his credibility.

Any legal opinion is a retrospective judgement. Accordingly, judges instruct attorneys what to look for in medical records, particularly as they can be construed as a barometer for the standard of care delivered. The term "standard of care" is both difficult to define and subtle. There are no simple responses to the question, "What is the standard of care?" Rather, it is best defined as the requirement that a physician use his best judgement, the way a prudent and equally well-trained physician would in the same or similar clinical circumstance.

To determine whether or not a physician used his "best judgement", it is important to examine two conditions precedent to that ideal: first, that the physician possess knowledge; and, second, that he exercise or apply that knowledge in a careful and skillful manner. If the physician hopes to proffer a medical record to defend his professional conduct, he needs to ensure that those conditions are clearly fulfilled within that record.

MEDICAL RECORD CONTENTS

General Guidelines

Entries in the record should demonstrate the physician's education, training and experience as applied to a particular case or clinical situation. In the eyes of the law, the record should reflect the physician's skill, i.e., clinical competence, and the effective and judicious way in which he has applied his knowledge. This surpasses merely gathering and recording salient medical facts, although that is important. It means revealing one's professional thinking and judgement. This minimizes the risk that a diagnosis or treatment decision will be subjected to a "second guess" or misinterpretation.

The manner in which information is conveyed makes a substantial difference. Frivolous comments, use of the vernacular, frequent sprinkling of meaningless abbreviations, or statements of moral judgement about patients, their families, or significant others are inappropriate. They suggest that the physician acted in a manner that was too informal, nonmedical, or unprofessional.

Specific Elements

A medical record should: (1) establish the most likely cause of the patient's problem, (2) support the diagnosis, (3) outline the treatment and management of the patient's condition, and (4) describe the patient's response to treatment or, if no response, the provider's subsequent action. Either too little or too much information causes problems. The record must provide enough meaningful medical data that another practitioner could step in and take over, when the attending physician is unavailable or should the patient be transferred.

An adequate medical record tells the clinical story of the patient's problem, describing its complexity and demonstrating its receipt of proper professional attention. Such a record is carefully prepared, complete, accurate, legible, germane, relevant, timely. It is wise to include a problem list, with new problems added as they develop and old ones addressed as corrected, stabilized, controlled, or eliminated. Any special circum-stances under which the patient is evaluated, such as an emergent or urgent situation, or one in which the patient is hostile, uncooperative, irrational, psychotic, intoxicated, or incompetent should also be recorded.

Prescribing practices are not usually questioned unless the record reveals an inadequate clinical evaluation, i.e., history, physical examination and appropriate ancillary studies, before a prescription is written. At a bare minimum, particularly in the case of controlled substances, the record should include entries that are consistent with a valid therapeutic indication for the prescription.

Informed Consent and Advance Directives

Before performing a complicated diagnostic or therapeutic procedure, particularly one that is invasive or requires anesthetic premedication, or before treating a patient with drugs that risk significant complications or side effects, the physician should obtain and adequately document the patient's informed consent. The record should reveal that the patient has been informed of the diagnosis, the contemplated procedure, its indications, associated risks, complications or side effects, the goal to be achieved, the reasonably available alternatives, and the expected outcome if nothing is done.

A laundry list need not be written out, but merely the fact that the most significant items among those categories were discussed with the patient, that the patient understood and agreed to the treatment after having been provided the opportunity to ask questions. A brief contemporaneous note to that effect, either in the outpatient or hospital record, should suffice to demonstrate informed consent. Hospital protocols may also require the patient's signature on a consent form, which should be witnessed, dated, and filed.

With an increasing focus upon the appropriate use of sophisticated medical technology at the end of life, a new concern with medical records has arisen. The law has stated that patients have a recognized right to be more directly involved in deciding the course of their care. Their wishes, however, can conflict with those of their family members or the recommendations of their physicians. All such discussions with patients or their surrogates, and all orders to institute, withhold or withdraw treatment must be clearly documented in the medical record. The record should also include relevant forms or directives executed by the patient. These should be consistently flagged so that, when urgent or emergent situations occur, the available treating staff can quickly and accurately ascertain the patient's expressed wishes and institute or withhold therapy accordingly.

The Competent Medical Record

The medical record should demonstrate rational decision making throughout. Documenting the selection of germane clinical facts and the synthesis of such facts into a differential diagnosis is a fundamental means to that end. The record should always provide sufficient data to explain how the professional's thinking led to a diagnostic or therapeutic decision. Moreover, the physician's professional conduct should be consistent with the analysis reflected in the medical record. If not, the record should carefully reconcile, by appropriate comment, any disparity between thought and action. A failure to provide that reconciliation may later support an inference of incompetence on the part of the physician.

SPECIAL PROBLEMS

Alterations

Legally, the provider who appears recurrently to find himself in deep water is the one who alters a medical record "after the fact." It is bad enough to prepare records that do not adequately document medical care as rendered, but to alter the record, especially after a claim is filed or following a bad result, is potentially

disastrous. Judges and jury members are naturally inclined toward a common sense postulate under such circumstances: if the physician had nothing to hide, why meddle with the record?

Should an erroneous order need rewriting or should an entry have been placed in the wrong patient's record, one should take care not to let a necessary correction appear to be an attempt to conceal. A single line should be drawn through the erroneous entry so that it may still be read, and that entry should be initialed, with the date and time noted. At the next available appropriate place in the record, another note should be written to explain the correction. The physician's signature, with the date and time, should be appended to the new entry, corresponding with the first line-out.

Internal Inconsistencies

One of the more unusual circumstances in which providers are "hung out to dry" on their records is when those records manifest a lack of internal consistency. A pertinent example involved a busy physician who noted in an admission history that the patient, a longstanding diabetic with severe peripheral vascular disease, had previously undergone a right below-the-knee amputation. Further, the patient was also described as experiencing incipient vascular problems and a plantar ulcer on the left foot. Unfortunately, the admission physical examination included a notation that the physician had palpated bilateral pedal pulses. At a subsequent malpractice trial, regarding an issue totally unrelated to the vascular problem and its treatment, this discrepancy created great embarrassment and unnecessary confusion.

Internal inconsistencies can also arise when notes are not written in a timely manner. Operative reports should be dictated as soon as possible after the procedure, especially when the surgery is unusually complex or complications have occurred. It is difficult, if not impossible, to defend a malpractice suit alleging negligent performance of complicated surgery when the operative note is dictated six months after the procedure was performed, reads like a textbook description, and mentions no problems. In one such case, the contemporaneously handwritten postoperative note described in detail the difficulties encountered by the surgeon during the procedure. Progress notes in the medical record from weeks after the procedure also gave contradictory information and described further the results of intraoperative errors and difficulties. Given these circumstances, the only sensible recommendation was to settle the case as soon as possible.

Jousting

Feuds or quarrels between physicians, or between physicians and other providers, have no place in the medical record. They may help demonstrate to a court that the staff was so involved in waging internecine battles that little or no attention was paid to the patient. For example, one internist always referred his patients who required surgery to a particular surgeon noted for his technical skill but not his knowledge of postoperative intravenous fluid management. The surgeon operated on a patient referred to him by the internist and proceeded to write intravenous fluid orders. The internist conducted rounds later that day and, dissatisfied with the surgeon's orders, wrote a progress note: "This horse's_____ may know a lot about surgery, but he knows absolutely nothing about fluids. Fluid orders changed - see order sheet." The surgeon made rounds early the next morning and drafted his own progress note: "If I am such a horse's _____, why do you keep calling me back to do your surgery?" Unfortunately, the patient died of complications. There was no evidence of any negligence or malpractice involved in the case. The defense of a suit brought by the surviving family was significantly compromised, however, by the unnecessary, inappropriate, and unwarranted comments of the two physicians involved.

When there is professional disagreement about the nature of orders to be written or similar issues, the topic should be discussed directly between providers. Comments in the record should always reflect a professional dialogue, not personal diatribes.

Maintenance

With medical care today more frequently being provided in an outpatient setting, it is critically important that the record of all visits by a patient to a physician be carefully maintained, lest it be suggested later that the physician failed to employ adequate diligence or that he abandoned the patient. In particular, the record should carefully document changes in the medical care. These include: (1) changes in diagnosis or impression; (2) changes in treatment; (3) new diagnostic procedures to be undertaken, with results of those studies; and (4) changes they suggest in diagnosis or treatment.

CONCLUSION

Experts in the field of medical records recommend that, at a minimum, six categories of information be provided in a medical record: (1) a complete history with a description of the present ailment or injury, recorded as nearly as possible in the patient's words; (2) the report of a physical examination revealing objective findings regarding subjective complaints and including significant negatives; (3) a record of diagnostic tests and all similar reports received concerning the patient; (4) an impression or a diagnosis (when a physician is able to form only an impression in the absence of additional diagnostic procedures, the word "diagnosis" should be avoided); (5) a record of treatment, with medications prescribed and procedures recommended or performed; and (6) the patient's response to treatment along with any indicated alterations in the treatment plan.

When a malpractice claim arises, the medical record may be one's only source of information regarding the diagnosis, the treatment plan, and the final evaluation and results in a particular case. Keeping carefully prepared, complete, accurate, legible, and timely medical records is not some incidental, ancillary legal obligation externally imposed on health care providers. It is, rather, an inherent component of sound medical practice and one that can afford the provider who renders proper care a nearly impregnable defense against a claim of negligence.